STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175338	A. BUILDING _____ B. WING _____	C 12/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BALDWIN HEALTHCARE & REHAB CTR LLC	**1223 ORCHARD LANE BALDWIN CITY, KS 66006**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigations #92354 and #94273.	F 000		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: The facility identified a census of 59 residents. The sample included 4 residents. Based on observation, record review and interview, the facility failed to review and revise the care plan for 2 of 4 sampled residents. (#1 regarding elopement and #4 regarding elopement and mobility status)	F 280		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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Findings included:

- Resident #1's diagnoses listed in the electronic medical record included: cognitive communication deficit, Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), abnormalities of gait and mobility, lack of coordination and muscle weakness.

The 9/24/15 14 day Minimum Data Set (MDS) recorded the resident with a Brief Interview for Mental Status (BIMS) score of 8, indicating moderately impaired cognition. The resident required extensive assist with bed mobility, transfers, walking, and locomotion. The resident used a walker or wheelchair for locomotion, and did not wander.

The Care Plan dated 9/25/15 recorded a goal that the resident would not wander into other residents rooms more than 2 times daily. The care plan included interventions to approach the resident in a calm and friendly manner, assess and manage unmet needs such as pain, toileting, fatigue and hunger; divert the resident by giving alternative objects or activity; encourage resident to attend activities of choice and adjust time spent with his/her tolerance and attention span; and familiarize the resident with his/her own belongings and surroundings. The care plan had a hand written intervention dated 9/29/15 that staff placed a wanderguard to the resident's wheelchair and directed staff to check the function each shift. This intervention was not available in the electronic clinical record for staff to review. The care plan did not include information regarding the resident's actual elopement on 10/2/15 or additional interventions

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to prevent elopement.

The Elopement evaluation dated 10/2/15 documented the resident was outside facility today, self-ambulated, had a diagnoses of Alzheimer's, and a history of wandering.

Review of the October 2015 Treatment Administration Record (TAR) revealed staff initialed the placement and function of the resident's wanderguard all three shifts from October 1-6.

The physician's order dated 9/29/15 directed staff to check function of the wander guard on the resident's wheelchair every shift.

Nurses Notes dated 9/29/15 at 9:51 AM recorded staff placed a wander guard to the resident's wheelchair this morning and would the monitor function every shift.

Nurses Notes dated 10/1/15 at 10:56 AM recorded the resident's wander guard was in place on his/her wheelchair, and staff checked to ensure it was working properly.

Nurses Notes dated 10/2/15 at 5:08 PM recorded the resident followed another resident out of the facility and proceeded down sidewalk as staff was being alerted. The resident pulled his/her wheelchair up to soft dirt and pulled him/herself onto his/her knees, and had a scrape to the knee.

Observations were unavailable as the resident discharged from the facility on 10/7/15.

During an interview on 11/20/15 at 10:30 AM, Administrative nursing staff B stated the resident

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had the alarm on the old wheelchair, went for home evaluation, and staff had not put him/her back in the original wheelchair so the wander guard was not on the resident. Staff placed the wanderguard on the resident on 9/29/15.

The facility policy for care plans dated 1/2/14 directed staff that the comprehensive care plan should be reviewed and revised a minimum of quarterly and as needed to reflect changing needs and goals. The care plan must be customized to each individual patient's needs.

The facility failed to review and revise the care plan regarding elopement and mobility status for this cognitively impaired resident.

- Diagnoses listed on the November 2015 Medication Review Report for resident #4 included: major depressive disorder, Alzheimer's Disease (progressive mental deterioration characterized by confusion and memory failure), pain, unspecified psychosis (any major mental disorder characterized by a gross impairment in reality testing) and convulsions.

The quarterly MDS dated 11/16/15 documented the resident with a Brief Interview for Mental; Status score of 3, indicating severely impaired cognition. The resident displayed inattention and disorganized thinking. The resident displayed physical and behavioral symptoms directed toward others. The resident rejected care and wandered 1-3 days. The resident required extensive assist with bed mobility, transfers, toilet use and personal hygiene and was independent with locomotion on and off the unit. The resident

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used a wheelchair for ambulation.

The Elopement Evaluation dated 11/12/15 at 4:24 PM revealed the resident can ambulate or self-propel independently, had a diagnosis of Alzheimer's disease and dementia, did not have a history of actual elopement or attempted elopement, did not have a history of wandering that placed the resident at significant risk of getting to a potentially dangerous place. (stairs, outside facility) The resident had not expressed the desire to leave, was unable to locate significant landmarks without assistance, and exhibited restlessness and agitation.

The care plan dated 11/6/15 recorded the resident used a broda chair (specialized reclining wheelchair) for positioning. the resident's wandering intruded on other residents' privacy, by wheeling into their rooms at times, and directed staff to approach the resident positively in a calm, accepting manner, provide diversional activities, redirect the resident out of others rooms, and for social services to visit and support the resident as needed. Upon review on 11/24/15 at approximately 10:30 AM, the care plan did not reflect the resident's actual elopement on 11/22/15, the 30 minute checks staff placed the resident on or any further interventions to prevent elopement.

Observation on 11/24/15 at approximately 10:00 AM revealed the resident in his/her standard wheelchair in the dining room. An attempt to interview the resident was unsuccessful as he/she was very confused. The resident self-propelled his/her wheelchair further into the dining room for an activity.

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Observation at 10:13 AM revealed the resident in the dining room at an exercise activity. There was no wanderguard noted to the resident's ankle or wrist.

The physician's progress note dated 10/21/15 recorded the resident was alert and confused and had depression, anxiety and falls.

Nurses notes dated 11/22/15 at 10:40 AM recorded staff observed the resident sitting in the doorway of the main dining room at 10:35 A.M. This nurse proceeded down to wellness unit to speak to the wellness nurse and observed the resident out by the picnic table in front of facility. This nurse immediately alerted aides to the resident being outside and they went to bring him/her back in. The resident had no history of exit seeking but did self-propel and wander around the facility, which was a normal daily routine for the resident.

Nurses notes dated 11/23/15 at 5:50 PM recorded the resident continued on 30 minute visual checks due to staff finding the resident outside on 11/22/15. The resident wandered in manual wheelchair around the facility per normal behavior and did not display and exiting behaviors.

The Elopement Evaluation dated 11/24/15 at 10:05 AM (4 days after the elopement) revealed the resident was able to ambulate or self-propel the wheelchair independently, had diagnoses of Alzheimer's disease and dementia, a history of actual elopement or attempted elopement, and a history of wandering that placed the resident at significant risk of getting into a potentially dangerous place. The resident was unable to

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locate significant landmarks without assistance, and displayed restlessness or agitation.

On 11/24/15 at 10:52 AM, licensed nursing staff D stated he/she was resident #4's charge nurse on Sunday when the resident eloped from the facility. The resident had his/her typical behavior on Sunday. The resident is alert and oriented to name only, gets around pretty good in the wheelchair, and he/she wandered up and down the halls. Licensed nursing staff D stated he/she did not see anyone come or go before the resident left the building. Licensed nursing staff D stated he/she saw the resident outside when he/she was walking back from the wellness unit. The resident was outside 3-4 minutes. The resident does not have a wanderguard at this time. I started a 30 minute check on the resident when staff brought him/her back in the facility on Sunday.

On 11/24/15 at 11:11 AM, direct care staff F stated he/she and direct care staff G both work on the wellness unit on Sunday. They were walking down the hall saw the resident at the end of the driveway. Direct care staff F stated he/she hasn't seen a wanderguard on the resident yet, we are locating one for him/her now. The resident wanders through the halls.

On 11/24/15 at 11:22 AM, direct care staff G stated he/she was working on Sunday and saw the resident outside, almost to the side walk. Direct care staff G stated the resident did not have a wanderguard when he/she eloped and did not know if the resident had one now or not. Direct care staff G stated he/she and direct care staff F went out and got the resident and brought him/her back in the facility.

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F 280	Continued From page 7 On 11/24/15 at 11:55 AM, administrative nursing staff C stated staff started 30 minute checks right after they brought him/her in, and there is a wanderguard on order. The resident was probably outside 5 minutes max. Administrative nursing staff C stated he/she feels like the 30 minute checks are adequate for monitoring the resident's safety at this time. On 11/30/15 at 2:32 PM, administrative nursing staff B confirmed there resident did not have a Broda chair any longer and that the care plan was not revised to reflect the resident's actual elopement on 11/22/15 or additional elopement prevention interventions. The facility policy for care plans dated 1/2/14 directed staff that the comprehensive care plan should be reviewed and revised a minimum of quarterly and as needed to reflect changing needs and goals. The care plan must be customized to each individual patient's needs. The facility failed to review and revise the care plan regarding elopement and mobility status for this cognitively impaired resident.	F 280		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		

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This REQUIREMENT is not met as evidenced by:
The facility identified a census of 59 residents. The sample included 4 residents sampled for elopement risk. Based on interview and record review, the facility failed to provide adequate supervision for 2 of sampled residents (#1 and #4). Resident #1, assessed at risk for elopement, left the facility without staff knowledge. Resident #4, a confused and independently mobile resident who wandered within the facility exited the facility without staff knowledge two days after the investigation for resident #1's elopement from the facility.

Findings included:

- Resident #1 admitted to the facility on 9/10/15.

Diagnoses listed in the electronic medical record included: cognitive communication deficit, Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), abnormalities of gait and mobility, lack of coordination and muscle weakness.

The 9/10/15 initial nursing assessment recorded the resident was alert and oriented to person only.

The 9/24/15 14 day MDS recorded the resident with a Brief Interview for Mental Status (BIMS) score of 8, indicating moderately impaired cognition. The resident required extensive assist with bed mobility, transfers, walking, and

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locomotion. The resident used a walker and wheelchair for locomotion, and did not wander.

The Care Plan dated 9/25/15 recorded a goal that the resident would not wander into other residents rooms more than 2 times daily. The care plan included interventions to approach the resident in a calm and friendly manner, assess and manage unmet needs such as pain, toileting, fatigue and hunger; divert the resident by giving alternative objects or activity; encourage resident to attend activities of choice and adjust time spent with his/her tolerance and attention span; familiarize the resident with his/her own belongings and surroundings. The care plan had a hand written intervention dated 9/29/15 that staff placed a wanderguard to the resident's wheelchair and directed staff to check the function each shift.

The clinical record lacked evidence of an elopement assessment prior to 10/2/15.

The Elopement evaluation dated 10/2/15 documented the resident was outside facility today, self-ambulated, had a diagnoses of Alzheimer's, and a history of wandering.

The Occupational Therapy note dated 9/30/15 at 7:43 PM recorded the therapist located a standard wheelchair to prepare for necessary seating equipment needed to assess for home evaluation tomorrow.

The Occupational Therapy note 10/1/15 at 4:57 PM recorded therapy staff completed a home assessment on this date.

Review of the October 2015 Treatment Administration Record (TAR) revealed staff

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initialed the placement and function of the resident's wanderguard all three shifts from October 1-6.

The physician's order dated 9/29/15 directed staff to check function of the wander guard on the resident's wheelchair every shift.

Nurses Notes dated 9/28/15 at 7:46 PM recorded the resident wandered throughout building and was unable to follow simple directions.

Nurses Notes dated 9/29/15 at 9:51 AM recorded staff placed a wander guard to the resident's wheelchair this morning and would the monitor function every shift.

Nurses Notes dated 10/1/15 at 10:56 AM recorded the resident's wander guard was in place on his/her wheelchair, and staff checked to ensure it was working properly.

Nurses Notes dated 10/2/15 at 5:08 PM recorded the resident followed another resident out of the facility and proceeded down sidewalk as staff was being alerted. The resident pulled his/her wheelchair up to soft dirt and pulled him/herself onto his/her knees, and had a scrape to the knee.

Observations were unavailable as the resident discharged from the facility on 10/7/15.

During an interview on 11/20/15 at 10:30 AM, Administrative nursing staff B stated the resident had the alarm on the old wheelchair, went for home evaluation, and staff had not put him/her back in the original wheelchair so the wander guard was not on the resident.

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During an interview on 11/20/15 at 10:41 AM, Administrative staff A stated the resident was outside in the dirt area on the edge of the parking lot. Another resident's family member saw him/her wheel out the door and up the sidewalk and alerted staff. The resident was outside total less than 3 minutes. Another resident let him/her out the door.

During an interview on 11/20/15 at 11:52 AM, therapy staff E stated he/she found the resident a different wheelchair on 9/30 because he/she was in a high back wheelchair when he/she first admitted but that wheelchair would not fit in his/her apartment when he/she went home. Therapy staff E stated he/she found the resident a regular sized wheelchair and he/she started using that wheelchair on 9/30. The old high back wheelchair went into the storage closet. Therapy staff E was not aware there was a wander guard on the resident's high back wheelchair at the time. The resident went for a home evaluation on 10/1, and never went back into the high back wheelchair after 9/30.

The facility provided Elopement Policy and dated 6/04 recorded the resident would be assessed upon admission as part of the Nursing Assessment, quarterly, and when staff discovered wandering behaviors with the potential for elopement. After a resident returned from an elopement, the nurse would either modify the existing care plan or develop an acute care plan.

The facility provided Wandering Device Policy dated 5/04 (in place at the time of resident #1's elopement) recorded when a resident had a potential for elopement and utilized a wandering device, the device would be maintained in a

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manner to protect their safety. Devices should be placed on the resident's dominant wrist, if possible.

The facility failed to provide adequate supervision for this cognitively impaired, dependent resident assessed at risk for elopement which resulted in the resident eloping from the facility.

- Diagnoses listed on the November 2015 Medication Review Report for resident #4 included: major depressive disorder, Alzheimer's Disease (progressive mental deterioration characterized by confusion and memory failure), pain, unspecified psychosis. (any major mental disorder characterized by a gross impairment in reality testing)

The quarterly MDS dated 11/16/15 documented the resident with a Brief Interview for Mental Status score of 3, indicating severely impaired cognition. The resident displayed inattention and disorganized thinking. The resident displayed physical and behavioral symptoms directed toward others. The resident rejected care and wandered 1-3 days. The resident required extensive assist with bed mobility, transfers, toilet use and personal hygiene and was independent with locomotion on and off the unit. The resident used a wheelchair for ambulation.

The Elopement Evaluation dated 11/12/15 at 4:24 PM revealed the resident can ambulate or self-propel independently, had a diagnosis of Alzheimer's disease and dementia, did not have a history of actual elopement or attempted elopement, did not have a history of wandering that placed the resident at significant risk of getting to a potentially dangerous place. (stairs,

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outside facility) The resident had not expressed the desire to leave, was unable to locate significant landmarks without assistance, and exhibited restlessness and agitation.

The care plan dated 11/6/15 recorded the resident's wandering intruded on other residents' privacy, by wheeling into their rooms at times, and directed staff to approach the resident positively in a calm, accepting manner, provide diversional activities, redirect the resident out of others rooms, and for social services to visit and support the resident as needed. Upon review on 11/24/15 at approximately 10:30 AM, the care plan did not reflect the resident's actual elopement on 11/22/15, the 30 minute checks staff placed the resident on or any further interventions to prevent elopement.

On 11/24/15 at 9:40 AM, Administrative staff A stated he/she didn't have much written down for the investigation because he/she hadn't had a chance to talk to all the staff. Administrative Staff A continued that they didn't know at this point how the resident got out.

Observation on 11/24/15 at approximately 10:00 AM revealed the resident in his/her wheelchair in the dining room. An attempt to interview the resident was unsuccessful as he/she was very confused. The resident self-propelled his/her wheelchair further into the dining room for an activity.

Observation at 10:13 AM revealed the resident in the dining room at an exercise activity. There was no wanderguard noted to the resident's ankle or wrist. At this time, direct care staff H confirmed the resident did not have a wanderguard on at

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	175338	A. BUILDING _____ B. WING _____	C 12/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BALDWIN HEALTHCARE & REHAB CTR LLC	1223 ORCHARD LANE BALDWIN CITY, KS 66006

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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this time, and that he/she used to have one on his/her wheelchair.

The physician's progress note dated 10/21/15 recorded the resident was alert and confused and had depression, anxiety and falls.

Nurses notes dated 11/22/15 at 10:40 AM recorded staff observed the resident sitting in the doorway of the main dining room at 10:35 A.M. This nurse proceeded down to wellness unit to speak to the wellness nurse and observed the resident out by the picnic table in front of facility. This nurse immediately alerted aides to the resident being outside and they went to bring him/her back in. The resident wore a sweatshirt and sweatpants. The resident had no history of exit seeking but did self-propel and wander around the facility, which was a normal daily routine for the resident.

Nurses notes dated 11/23/15 at 5:50 PM recorded the resident continued on 30 minute visual checks due to staff finding the resident outside on 11/22/15. The resident wandered in manual wheelchair around the facility per normal behavior and did not display and exiting behaviors.

The Elopement Evaluation dated 11/24/15 at 10:05 AM (4 days after the elopement) revealed the resident was able to ambulate or self-propel the wheelchair independently, had diagnoses of Alzheimer's disease and dementia, a history of actual elopement or attempted elopement, and a history of wandering that placed the resident at significant risk of getting into a potentially dangerous place. Was unable to locate significant landmarks without assistance, and displayed

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restlessness or agitation.

On 11/24/15 at 10:52 AM, licensed nursing staff D stated he/she was resident #4's charge nurse on Sunday when the resident eloped from the facility. The resident had his/her typical behavior on Sunday. The resident is alert and oriented to name only, gets around pretty good in the wheelchair, and he/she wandered up and down the halls. Licensed nursing staff D stated he/she did not see anyone come or go before the resident left the building. Licensed nursing staff D stated he/she saw the resident outside when he/she was walking back from the wellness unit. The resident was outside 3-4 minutes. The resident does not have a wanderguard at this time. I started a 30 minute check on the resident when staff brought him/her back in the facility on Sunday. Maintenance staff was not contacted and did not come to the facility and no one checked the function of the doors on that shift. The resident is not safe to be outside by him/herself with dementia.

On 11/24/15 at 11:11 AM, direct care staff F stated he/she and direct care staff G both work on the wellness unit on Sunday. They were walking down the hall saw the resident at the end of the driveway. Direct care staff F stated he/she hasn't seen a wanderguard on the resident yet, we are locating one for him/her now. The resident wanders through the halls, and he/she is not safe outside alone.

On 11/24/15 at 11:22 AM, direct care staff G stated he/she was working on Sunday and saw the resident outside and almost to the side walk. Direct care staff G stated the resident did not have a wanderguard when he/she eloped and did

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not know if the resident had one now or not. Direct care staff G stated he/she and direct care staff F went out and got the resident and brought him/her back in the facility. The resident is not safe outside alone.

On 11/24/15 at 11:55 AM, administrative nursing staff C stated the resident is not safe alone outside. Staff started 30 minute checks right after they brought him/her in, and there is a wanderguard on order. The resident was probably outside 5 minutes max. Administrative nursing staff C stated he/she feels like the 30 minute checks are adequate for monitoring the resident's safety at this time.

On 11/24/15 at 11:36 AM, Administrative staff A stated the facility shortened up the time on the front door delay yesterday from 30 to 15 seconds. The initial intervention would've been to put a wanderguard on the resident, but that wasn't done yet because the batteries were dead in the extra wanderguards we had. We ordered one this morning that should be here tomorrow. Checks will remain in place until the band is on. The resident wanders from one end of the facility to the other.

On 11/24/15 at 11:43 AM, maintenance staff I stated he/she was not called in after either elopement to check the doors; heard about it yesterday and shortened the delay time from about 32 seconds to 15 seconds.

The elopement policy dated 5/15/14 (in place at the time of resident #4's elopement) directed staff to update the care plan to address post elopement evaluation and use of wandering device, if indicated, and review with caregivers.

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F 323	Continued From page 17 The facility failed to provide adequate supervision to prevent this cognitively impaired resident from exiting the facility without staff knowledge.	F 323		